MAXIMIZING HEALTH:
A Framework

Massachusetts Substance Abuse
Prevention Framework

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MAXIMIZING HEALTH: A FRAMEWORK

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INTRODUCTION

The Massachusetts Collaborative for Action, Leadership, and Learning (MassCALL) was established in part to assist state agencies and others in the development of a substance abuse prevention framework for Massachusetts.

MassCALL enlisted Massachusetts leaders in substance abuse prevention from state agencies, coalitions, community-based organizations, and other interested parties to develop the framework's rationale and key concepts. The state agencies represented included the Department of Education, Department of Public Health, Department of Social Services, Department of Youth Services, Executive Office of Health and Human Services, Executive Office of Public Safety, Governor's Alliance Against Drugs, and Governor's Highway Safety Bureau.

This Statewide Framework will guide state agencies, coalitions, schools, and community organizations in planning and implementing substance abuse prevention policies and programs to reduce substance abuse, particularly among youth and young adults. It is based on promoting close collaboration, inclusion, and cultural competence among state and local planners, practitioners, evaluators, and others in order to maximize resources and balance the evidence from prevention research with the wisdom of practice.

BACKGROUND

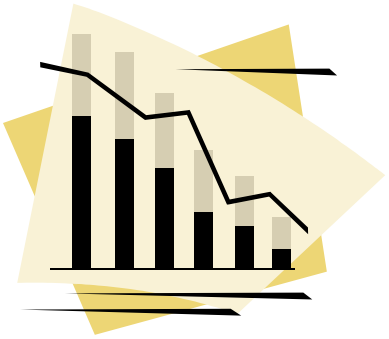
Nature of the Problem

This section briefly reviews the prevalence of substance abuse in Massachusetts, trends in substance use, and implications of use across the life span. Given the consequences of substance abuse that may follow a young person throughout his or her life, youth represent a prevention priority. Still, due to the complexities of social contexts within which young adults live, any approach that is singularly focused on adolescents' substance use to the exclusion of adult and community-based substance abuse prevention strategies is unlikely to succeed. The makeup of the population of Massachusetts is changing, and census and other datasets cite race/ethnicity as contributing factors and determinants of health status patterns and health services practices in the U.S. (Kreiger, 2000). This document, therefore, is intended to serve as a guide in addressing substance abuse prevention across the lifespan of diverse populations.

Prevalence[1]

Almost half (47%) of U.S. residents 12 and older reported being current drinkers (defined as use within the last 30 days) and 30% reported current use of a tobacco product in the 1999 National Household Survey[2]. As these figures suggest, alcohol and tobacco use is common across much of American society.

Less common, but still prevalent, are substance use rates for illegal drugs. U.S. residents of all ages report current illegal drug use. As Figure 1 shows, there are very low illegal drug use rates at early ages, a pronounced increase in the later teen years which peaks in the early 20s, followed by a general, though gradual, decline in use among people in their 30s, 40s, and 50s (SAMHSA, 2000).



Percent FIGURE 1: Illicit drug use by age: 1999 National Household Survey

Massachusetts has illicit substance use rates (10%) consistent with other industrialized states but higher than the national average (7%). As seen in Table 1, current illicit drug use, including marijuana, was reported by 16% of young people between the ages of 12-17 and 26% of 18-25 year olds. Binge alcohol drinking (defined as drinking five drinks or more on one occasion) was reported by 15% of teens 12-17, 49% of young adults 18-25, and 22% of adults 26 years old and above. Cigarettes were used in the month prior to the survey by 17% of 12-17 year olds and 41% of 18-25 year olds (SAMHSA, 2000).

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[1]Prevalence is a measure of the extent and/or intensity of substance use in a population. For example, the current prevalence of smoking is often measured as the proportion of respondents who said they had smoked a cigarette at least once in the past 30 days.

[2]To maximize comparability across data sources, it was decided to use survey data for the same years from the National Household Survey and the Massachusetts Youth Risk Behavior Survey. The most recent year for which data are available from both sources is 1999.

{Table here}
TABLE 1: 1999 use of selected drugs during the past month by age group in Massachusetts[3]

The interaction of substance use with other behaviors may amplify an individual's potential for harm. According to the Massachusetts Youth Risk Behavior Survey (MYRBS) results (MA-DOE, 1999), substance use is frequently associated with other risk behaviors, including violence and early and risky sexual behavior. For example:

- High school students who had used alcohol within the last 30 days were over twice as likely to report carrying a weapon in the past 30 days (21% versus 8%) and nearly twice as likely to have been in a fight in the past year (48% versus 25%) (MA-DOE, 1999).
- High school students who had used an illegal drug within the last 30 days were more likely than those who had never used drugs to report higher risk behaviors such as weapon carrying (23% versus 7%), dating violence (19% versus 5%), sexual intercourse (47% versus 15%), and attempted suicide (12% versus 4%) in the last month (MA-DOE, 1999).

While these data indicate that substance abuse is a serious and complex problem among Massachusetts' youth, it should be emphasized that most adolescents are not current alcohol, tobacco, or other drug users. Also, recent data suggest that there have been positive changes in use rates among adolescents. For example, among Massachusetts' high school students, recent alcohol use and binge drinking, which had risen from 1993 to 1995, has leveled off. In addition, a substantial increase in the rate of recent cigarette smoking from 1993 to 1995 has leveled off, as has the rate of current marijuana use after growing significantly from 1993 to 1997 (MADOE, 1999). Prevalence rates of various subgroups (racial, ethnic, gender) differ markedly, and these differences should be taken into account when planning prevention and treatment services.

The flattening of recent trend data represents encouraging news for the state agencies in Massachusetts that have focused considerable resources on substance abuse prevention over the last decade. Massachusetts state agencies' substance abuse prevention strategies are generally consistent with effective prevention practices identified by current prevention research. For example, agencies tend to use multiple strategies across multiple settings (Downey and Haley, 1999).

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[3]Adopted from Table 3.36 of National Household Survey, 1999, chapter 3. State Estimates of Substance Use.

While Massachusetts state agencies have worked together and continue to work together collaboratively, it has been recognized that more coordination is needed to further address the challenges of substance abuse in the Commonwealth. This need is supported by findings from the Social Indicator Study (SIS). The SIS uses social indicator data, namely risk and protective factors[4], to measure the relative need for substance abuse prevention services in each of Massachusetts' 351 municipalities. The study found that while many towns are relatively high in both risk and protective factors, some towns experienced high levels of protective factors and low levels of risk factors. Still, other towns had high levels of risk and very low levels of protective factors (Kreiner, Soldz, Elliot, Berger, & Reynes, 1998). These findings point to a need for a more coordinated distribution of resources that will address the disparities of risk and protective factors across communities.

Under the MassCALL banner, agencies sent representatives to develop a coordinated and comprehensive substance abuse prevention framework. This Framework is intended to guide future prevention efforts across the Commonwealth.

There are four key concepts that have guided the development of this Framework.

Cost effectiveness of prevention. One out of every eight dollars spent on personal health care in the United States is spent on health care for people suffering from diseases associated with substance abuse. Combined effects of tobacco, alcohol, and drugs cause a greater toll on the health and well being of Americans than any other single preventable factor (Costs of Substance Abuse in America, 1999). Prevention can play a significant role in reducing the economic burden of substance abuse. For example, it is estimated that for every dollar spent on drug abuse prevention, communities can save four to five dollars in costs for drug abuse treatment and counseling (Sloboda & David, 1997).

Ecological approach. People operate within multiple social and physical environments that influence their health behaviors, including substance use. An ecological approach to substance abuse prevention addresses these multiple, interrelated systems of influence. Five levels of influence have been identified: (1) individual factors, (2) interpersonal factors, (3) institutional or organizational factors, (4) community factors, and (5) public policy factors (McLeroy, Bideau, Steckler, & Glanz, 1988). An ecological approach posits that changes in these five social and physical environments shape changes in individual behavior (Goodman, 2000). The influences are also reciprocal. In other words, health behavior both influences and is influenced by the social environment.

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[4]Risk factors are individual, family, peer, school, and community factors that contribute to drug use and abuse. Protective factors are individual, family, peer, school, and community factors that protect against drug use and abuse.

Collaboration. Effective prevention requires engaging multiple community systems at multiple levels. This, in turn, implies a need for collaboration. Collaboration is a process of participation through which individuals, groups, and organizations come together in a mutually beneficial and well-defined relationship to work toward results they are more likely to achieve together than alone (Winer & Ray, 1994). While building relationships among diverse individuals and organizations can be difficult, collaboration also provides important benefits.

- Collaboration can have a positive impact on the health and quality of life of individuals, organizations, and communities.
- Collaboration brings together multiple perspectives that help to define issues and create solutions.
- Collaboration increases responsibility for the common good.
- Collaboration maximizes resources.
- Collaboration provides political strength that can help bring about change.

(Lasker, 1997; Bracht, 1999; CDC-ASTDR, 1997)

Cultural competence. For prevention programs and collaborations to be successful, they must be inclusive and reflect the cultures of the participating groups. Cultural competence is defined as a set of behaviors, attitudes, skills, and policies that allow individuals and organizations to increase their respect for, and understanding and appreciation of, cultural differences and similarities within and among groups. A culturally competent individual, program, or system is willing and able to draw on and build upon community-based values, traditions, and customs. In addition, cultural competence includes working with knowledgeable persons of and from the community in developing strategies to meet culturally unique needs (Woll, 1995). Effective, culturally competent programs and collaborations are based on recognizing diversity within cultures, as well as between cultures. They also recognize that different groups are best served and led by people who are part of and/or "in tune with" the culture of those groups, and understand that building on the strengths and differences of different cultures enhances the capacity of all.

Effective cultural competence is an ongoing developmental process of refining, expanding, and updating an individual's, an organization's, and/or a community's understanding of different cultures. It requires a long-term commitment. It also requires multi-faceted and multi-level approaches (HRSA/MCHB, 1996). A multifaceted approach suggests that there is no single activity or event that will ensure the cultural competence of an agency or staff. Consequently, a multi-faceted prevention approach that is culturally competent must address policy, administrative, program/provider, community, and research issues.

Critical areas of concern in developing a multi-culturally competent service system for a prevention program include access, engagement, and retention (CT-DMHSA, 2000). Access is the degree to which services are quickly and readily available. Engagement refers to the ability to promote an individual/community's initial commitment to participate in a prevention program. Retention refers to maintaining the commitment of an individual/community to a prevention program.

In January of 1998, the Office of Civil Rights (OCR) with the United States Department of Health and Human Services (USDHHS) issued policy guidance to all federally-funded

recipients. "In order to ensure compliance with Title VI, recipient/ covered entities must take steps to ensure that persons with Limited English Proficiency (LEP) who are eligible for their programs or services have meaningful access to health and social service benefits that they provide." The key to providing meaningful access is to ensure that the recipient/covered entity and LEP person can communicate effectively. Steps to ensuring meaningful access to LEP persons and Title VI compliance include: assessment of the language needs of the population to be served, development of comprehensive written policy on language access, training of staff regarding policy implementation, and vigilant monitoring to ensure LEP persons meaningful access to health and social services benefits. The MassCALL framework supports the use of the national standards for culturally and linguistically appropriate services in health care as a guide for developing, implementing, and monitoring prevention programs (USDHHS/OCR, 2000).

Based on the four key concepts discussed above, the following eight recommendations are proposed to enhance a collaborative statewide approach to substance abuse prevention. The first four recommendations concern the application of scientific principles to substance abuse prevention: common methods for assessing needs and resources, an examination of risk and protective factors as a way to link needs and interventions, promotion of science-based practices, and support of environmental strategies. Recommendations five through eight relate to enhancing systems to facilitate state and local learning: support of innovations, evaluating efforts, creating a system to coordinate evaluation, and building collaborative leadership.

Recommendation 1: Apply Common Methods for Assessing Local Substance Abuse Prevention Needs and Resources

A science-based approach to prevention calls for identifying local needs and resources so that appropriate interventions can be selected or designed. Massachusetts needs a collaborative, systemic method to assess local and state prevention needs. At the same time, community stakeholders must be able to identify specific local problems. An ideal method for assessing needs and resources would:

- Measure needs and resources in a consistent way at the town-level
- Be reliable[5]
- Be valid[6]
- Capture substance abuse prevalence
- Capture substance abuse-related health problems
- Capture risk
- Capture protection

At present, there are four major instruments used to assess substance abuse prevention need in Massachusetts, all of them reliable and valid. The Massachusetts Youth Health Survey and the Massachusetts Youth Risk Behavior Survey, both administered bi-annually in alternating years, measure youth substance abuse prevalence. Both are sampled by school district and school classroom to describe youth behavior in the state as a whole and do not provide information about individual towns and cities. While both capture prevalence and risk, only the

Massachusetts Youth Health Survey includes measures of protection; neither is designed to measure community resources.

The Massachusetts Behavioral Risk Factor Survey System (MBRFSS), administered to adults, measures substance abuse prevalence and risk, and is over-sampled in selected cities. It does not measure needs for most towns and does not measure community resources. In contrast, the MassSNAP indexes of substance abuse related problems, risk, and protection do apply at the town level (Kreiner, Soldz, Berger, Elliot, Reynes, Williams, & Rodriguez-Howard, 2001). These indexes are not focused solely on youth. Whereas the Massachusetts Youth Health Survey, MYRBS, and MBRFSS all measure prevalence, the MassSNAP indexes measure the presumed results of substance abuse and correlates of those results. Table 2 summarizes selected features of the four instruments.

As seen below in Table 2, none of these instruments is an ideal method for assessing local needs and resources[7]. Therefore, there is a need to develop new measures, or to refine existing measures to assess substance abuse prevalence and related resources at the state and local level. This includes increasing the capacity to report data about different cultural groups. Such statewide measures should be augmented by local qualitative and quantitative data related to both needs and resources.

{Insert table}
TABLE 2: Instruments used to assess needs and measures related to substance abuse in Massachusetts

Recommendation 2: Promote a Risk and Protective Factor Approach to Substance Abuse Prevention

Risk factors are individual, family, peer, school, and community factors that contribute to drug use and abuse. Protective factors are individual, family, peer, school, and community factors that protect against drug use and abuse. Research suggests that substance abuse is the result of a complex interplay of psychological, social, biological, interpersonal, and other environmental influences. While risk factor research does not generally claim causal links between risks and later problems, if the contribution of risk factors is high and not offset by protective factors, the probability of substance abuse and other health related problems is also high (Gardner, Brounstein, & Stone, 2001).

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[5]A method of assessing need is reliable if it measures need, ideally with different population samples and at different times, with relatively little measurement error. One test of the reliability of measures of a construct such as "self-efficacy," for example, is whether the multiple items used to measure this construct are highly inter-correlated.
[6]A method of assessing need is valid if it in fact measures what it purports to measure. For example, one test of the validity of measures of being at risk for substance abuse is whether they predict increased substance use or abuse.
[7]Each of the first three instruments, if sampled at the town level, could satisfy the town-level criterion. This sampling approach has so far proven to be prohibitively expensive.

State and local agencies that fund substance abuse prevention in Massachusetts vary in the degree to which they apply a risk and protective factor approach when developing funding requests and implementing programs within local communities. Massachusetts needs to increase its capacity at the state and local levels to apply a risk and protective factor approach. A risk and protective factor approach can be used to assess both individual and community resources. Furthermore, such an approach allows a community to critically select the most appropriate intervention and tailor it to reflect community needs.

While helpful in developing a methodical and comprehensive scientific approach to prevention, a risk and protective model must be used critically. For example, communities' racial, ethnic, national origin, gender, sexual, and age compositions differ considerably across the Commonwealth and may combine in different ways to create either risk or protective factors. The Center for Substance Abuse Prevention's "Web of Influence" (SAMHSA/CSAP, 1999) identifies the multiple domains and interactions where risk and protective factors may be mapped (see Figure 2). Despite this helpful schematic model, the interactions are not necessarily linear, nor are they static over time. Furthermore, many current analyses aggregate risk and protective data from individuals to assess community needs. While such an analysis provides a great deal of information about individuals and some information on populations, it may miss other risk and protective indicators within schools, neighborhoods, communities, and institutions.

{Insert figure 2: Web of Influence}

Even with its limits, a major advantage of this model is that it addresses the "whole" individual. It places the individual in the context of peer, school, community, family, and society/environment. In addition, it shows the connection of substance abuse to other problem behaviors.

Recommendation 3: Promote Science-Based Prevention

Twenty years of research and practice in the field of substance abuse prevention have yielded much information about what works. This research has led federal agencies and foundations to promote science-based substance abuse prevention and science based programs. Generally, science-based programs are considered to be those that show evidence of effectiveness—that is, produce measurable positive results related to substance use or to risk and protective factors associated with substance use. According to the Center for Substance Abuse Prevention (SAMHSA/CSAP, 1999), there are several advantages to adopting science-based prevention programs:

- They maximize the chances of achieving positive prevention outcomes;
- It is more efficient to apply and, if needed, adapt a science-based program than to develop a program from scratch and to prove it is effective; and
- The risk of producing unintended negative outcomes is reduced; in general, programs that produce negative outcomes are not deemed science-based.

While science-based models offer significant advantages, there are at least three issues that Massachusetts' agencies and organizations are advised to address. The first is how to define which programs qualify as science-based. At present, different federal agencies promoting science-based prevention use different criteria to define science-based programs. Another complication is that the lists of science based programs generated by these agencies change.

The second issue concerns the need to match a science-based program with local needs, culture, and conditions. In some cases there may not be a science-based program that matches a specific local need. In other cases, a science-based program may exist, but it cannot be implemented without adapting it to local conditions. For example, it may be necessary to change a program's content and language to make it appropriate for the selected population. The dilemma is that adaptations may reduce the chances that the program will be as effective as it was in its original version.

The third issue is the need to balance the evidence from research on science-based programs with the wisdom of practice. This means investing in learning how well science-based prevention works when implemented outside the "laboratory" settings where often more resources are made available to support the program than are typically available to local practitioners. It also means respecting and attending to the insight that practitioners bring to prevention.

Recommendation 4: Develop and Support Environmental Strategies

While individuals may make the choice to use drugs, these choices are influenced by the environments in which they work, play, and live. Thus, effective prevention must not only focus on individuals but also on the environments that they share or in which they live.

Most substance abuse prevention efforts have focused on individuals and groups, while strategies addressing the environment have generally been underutilized. Recently, however, there has been increased interest in and emphasis on environmental prevention approaches that seek to change the overall context within which substance abuse occurs. Environmental prevention efforts focus on availability, norms, and regulations (Mosher & Jernigan, 1998). Some Massachusetts examples of successful environmental strategies include tobacco control efforts to reduce retail access to tobacco products by minors, community-based vendor education, compliance checks, media campaigns, removal of vending machines, regulations banning smoking in restaurants, and strengthening school tobacco policies and their enforcement.

Some environmental strategies, just as some programs that focus on individuals, are science-based. And the same three concerns about science-based programs that were discussed in the previous section also apply to science-based environmental strategies: (1) differences in how science-based strategies are defined, (2) imperfect match between strategies and local needs, and (3) the need for adaptation to local needs, culture, and conditions. In addition, some environmental strategies may be difficult to implement because they lack a detailed blueprint for implementation or because their implementation requires collaboration among many sectors of the community.

Environmental strategies, however, offer at least three distinct advantages over individual strategies (Fisher, 1999). First, environmental strategies have the ability to reach all members of selected populations. For example, training vendors to check IDs and enforcing the law against selling to minors reduces the availability of alcohol for all local youth. Second, environmental strategies may produce results faster than strategies focused on individuals. For example, enforcement of the minimum tobacco purchase age may contribute to an immediate reduction in youth tobacco use, whereas a school-based tobacco prevention curriculum may produce results

after months or years. Third, environmental approaches are easier to maintain and more cost-effective. For example, the cost associated with enforcement efforts may be considerably lower than that associated with educating each new generation of youth regarding substance abuse.

Recommendation 5: Continue Support of Innovative Prevention Strategies

Massachusetts is committed to the improvement of substance abuse prevention. Therefore, in addition to funding science-based strategies, it also encourages the development of innovative strategies, both individual and environmental. These strategies may add to the body of substance abuse prevention knowledge. Innovative strategies are tailored to specific population needs and are based on a "logic model" that links needs, resources, programs/strategies, and short and long term outcomes (SAMHSA/CSAP/NECAPT, 2001) rather than extensive research evidence. These strategies should be implemented on a limited basis; for example, when there is no appropriate science-based program to meet identified community needs.

Innovative prevention strategies must be guided by science-based principles for effective program design. Examples of these principles include: (1) strategies should be comprehensive and coordinated to address locally-determined gaps in services; (2) strategies should be gender, developmentally, geographically, and otherwise culturally relevant; (3) the more risk factors in a population the more intensive and lasting the interventions need to be; (4) interactive teaching methods, e.g., skill development and practice, are more effective than didactic methods; and (5) 11 strategies that focus on family, school, and community factors are more effective than strategies that focus on only the individual. Specific principles for individual, family, peer, school, and community factors are outlined in Gardner, Brounstein, & Stone (2001) and in Sloboda & David (1997).

Recommendation 6: Support Evaluations of Prevention Programs and Related Prevention Systems

Learning about what works in Massachusetts prevention at both the program and state levels depends in large part on collecting evaluation data about an intervention or initiative. Federally recognized science-based prevention models have undergone rigorous evaluation that includes measurement of control groups, careful documentation of program elements, and extensive measurement of program outcomes. At present, process and outcome evaluations are not routinely required as part of Massachusetts prevention initiatives. It is recommended, therefore, that process and outcome evaluations be supported as an increasingly routine part of new prevention initiatives. This will not only increase knowledge about effective prevention practice in Massachusetts but will also build local and state-level capacity to conduct well-designed process and outcome evaluations.

Recommendation 7: Establish a System to Coordinate and Support Local and Statewide Evaluation Processes

Establishing a system to coordinate, develop, and share evaluation techniques, tools, and data will leverage evaluation resources and will maximize the usefulness of local and state evaluations by improving their quality. The following are examples of three components of such a system:

- A statewide evaluation group to inform and coordinate evaluation efforts in the state;
- A clearinghouse for evaluation protocols, instruments, and data; and
- Coordination and agreement regarding core process and outcome measures among state agencies that fund substance abuse prevention initiatives.

The statewide evaluation group will help specify an initial set of prevention evaluation criteria and will help ensure that needed adjustments to evaluation criteria, protocols, and library resources are made in a timely manner. Secondly, it will facilitate the incorporation of cultural factors such as language, acculturation, and family structure and tradition into evaluation design and procedures. In addition, the group will ensure that multiple stakeholder perspectives inform these criteria and adjustments. The creation of an evaluation clearinghouse will increase the resources available to statewide and local evaluators. Finally, agreements on core process and outcome measures will accelerate statewide learning about which interventions work best with which populations and in which settings. Taken together, these components will greatly enhance the state's ability to identify effective prevention practices, to ensure that they are being implemented well, and to assess their impact on substance abuse.

Recommendation 8: Maintain a Statewide Substance Abuse Prevention Advisory Council
A statewide advisory council comprised of representatives from state agencies and community organizations will guide implementation of this Framework. The Advisory Council will guide the coordination of substance abuse prevention efforts statewide. The Council will also work with others addressing related health issues such as violence, responsible sexual behavior, suicide, and other mental health issues to develop an integrated approach to prevention and promote the health of individuals, families, and communities in the Commonwealth.

Specifically, this Advisory Council will:

- Advise the governor regarding substance abuse prevention.
- Provide guidance on the implementation of the recommendations from the Massachusetts Substance Abuse Prevention Framework.
- Provide guidance on the development of systems to coordinate communications, funding, and technical assistance.
- Support the integration of substance abuse prevention with other health initiatives.

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